The City of Milwaukee
Summary of Dental Insurance Benefits
Effective January 1, 2014

City of Milwaukee
Summary of Dental Insurance Benefits

Class Description	All Active Full Time Employees - City General		All Active Full Time Employees - Fire		All Active Full Time Employees - Police	
	In-Network	Out-of-Network*	In-Network	Out-of-Network*	In-Network	Out-of-Network*
Reimbursement	Negotiated Fee Schedule	R&C - 80th Percentile	Negotiated Fee Schedule	R&C - 80th Percentile	Negotiated Fee Schedule	R&C - 80th Percentile
Type A – Preventive (Preventive and Diagnostic Services)	100%	100%	80%	80%	80%	80%
Type B – Basic (Restorative, Oral Surgery, Periodontics and Endodontic Services)	80%	80%	80%	80%	80%	80%
Type C – Major (Prosthodontics and Prosthetic Services)	80%	80%	80%	80%	80%	80%
Calendar Year Deductible applies to: ▪ **Individual** ▪ **Family**	B & C $25 $75 Aggregate	B & C $25 $75 Aggregate	B & C $25 $75 Aggregate	B & C $25 $75 Aggregate	B & C $25 $75 Aggregate	B & C $25 $75 Aggregate
Calendar Year Maximum *(applies to A,B,C services)*	$1,000 (Type B,C) No annual maximum for Type A	$1,000 (Type B,C) No annual maximum for Type A	$1,000	$1,000	$1,000	$1,000
Type D - Orthodontia	50%	50%	60%	60%	60%	60%
Orthodontia Lifetime Maximum	$1,200	$1,200	$1,000	$1,000	$2,000	$2,000

* Out of Network benefits are payable for services rendered by a dentist who is not a participating provider. The Reasonable and Customary charge is based on the lowest of (1) the dentist's actual charge (the 'Actual Charge'), (2) the dentist's usual charge for the same or similar services (the 'Usual Charge') or (3) the charge of most dentists in the same geographic area for the same or similar services as determined by MetLife (the 'Customary Charge'). Services must be necessary in terms of generally accepted dental standards.

In Network Savings* Example

This hypothetical example** shows how receiving services from a participating dentist can help save you money.

Your Dentist says you need a Crown, a Type C service —

Negotiated Fee: $670.00

Dentist's Usual Fee: $1,462.00

IN-NETWORK When you receive care from a participating dentist		**OUT-OF-NETWORK** When you receive care from a non-participating dentist	
Dentist's Usual Fee is:	$1,462.00	Dentist's Usual Fee is:	$1,462.00
The Negotiated Fee is:	$670.00	The Negotiated Fee is:	$670.00
Your Plan Pays:		***Your Plan Pays:***	
50% x $670 Negotiated Fee:	- $335.00	50% x $670 Negotiated Fee:	- $693.00
Your Out-of-Pocket Cost:	$335.00	Your Out-of-Pocket Cost:	$693.00
In this example, you save $358.00 ($693.00 minus $335.00)… by using a participating dentist.			

*Savings from enrolling in the MetLife Preferred Dentist Program will depend on various factors, including how often participants visit the dentist and the cost for services rendered.
**Please note: This is a hypothetical example that reviews a porcelain/ceramic crown (D2740) in the Philadelphia area, zip 19151. It assumes that the annual deductible has been met.
***Reasonable and Customary (R&C) charge is based on the lowest of (1) the dentist's actual charge, or (2) the charge of most dentists in the same geographic area for the same or similar services as determined by MetLife. The example shown reflects the 80th percentile R&C fee.

Please note: This example assumes that your annual deductible has been met.

Frequency & Allocations / Exclusions

(Custom Comprehensive (Flex) - Custom Standard (Flex))

Class Description: All Active Full Time Employees - City General, Fire and Police (Child(ren) covered to the end of the year in which the child turns Age 26, unless where otherwise noted)	
TYPE A ***Benefits are payable immediately from the start date of an individual's benefits***	
▪ Examinations	▪ 2 times in 1 calendar year
▪ Examinations – Problem Focused	▪ Combined with Examinations Limit
▪ Prophylaxis: Cleanings	▪ 4 times in 1 year
▪ Sealants	▪ 1 per molar in lifetime for a child to age 25
▪ Space Maintainers	▪ Frequency to be determined
▪ Fluoride	▪ 2 times in 1 calendar year for a dependent child under age 19
▪ Full Mouth X-Rays	▪ Once in 36 months
▪ Bitewing X-Rays	▪ 2 times in 1 calendar year
▪ Periapical X-Rays	
▪ Other X-Rays	
TYPE B ***Benefits are payable immediately from the start date of an individual's benefits***	
▪ Amalgam Fillings	▪ Frequency to be determined
▪ Root Canal	▪ Frequency to be determined
▪ Periodontal Maintenance	▪ 2 periodontal treatments in 1 calendar yr, includes cleanings (total comb: 2)*
▪ Periodontal Surgery	▪ 1 per quadrant in any 36 month period
▪ Scaling & Root Planing	▪ 1 per quadrant in any 24 month period
▪ Prefabricated Crowns	▪ 1 per tooth in 3 Years
▪ Emergency Palliative Treatment	
▪ Resin Composite Fillings(excludes coverage for composite fillings on molars)	
▪ Oral Surgery: Simple Extractions	
▪ Oral Surgery: Surgical Extractions	
▪ Other Oral Surgery	
▪ General Services	
TYPE C ***Benefits are payable immediately from the start date of an individual's benefits***	
▪ Crown Buildups / Post Core	▪ 1 per tooth in 5 calendar years
▪ Repairs	▪ Frequency to be determined
▪ Recementations	▪ Frequency to be determined
▪ Dentures	▪ 1 in 5 calendar years
▪ Dentures – Rebases / Relines	▪ 1 in 3 Years
▪ Denture Adjustments	▪ Frequency to be determined
▪ Fixed Bridges	▪ 1 in 5 calendar years
▪ Inlays / Onlays /Crowns	▪ 1 replacement per tooth in 5 calendar years
▪ Implant Services	▪ 1 per tooth position in 5 calendar years
Orthodontics ***Benefits are payable immediately from the start date of an individual's benefits***	
▪ Orthodontic Diagnostics	
▪ Orthodontic Treatment	

**** General and Fire plans include 4 periodontal treatments in 1 calendar year (total combined: 4)***

Exclusions
All Active Full Time Employees – General, Fire and Police
▪ Services which are not dentally necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which we deem experimental in nature. ▪ Services for which a covered person would not be required to pay in the absence of dental insurance. ▪ Services or supplies received by a covered person before the insurance starts for that person. ▪ Services which are neither performed nor prescribed by a dentist except for those services of a licensed dental hygienist which are supervised and billed by a dentist and which are for scaling or polishing of teeth or fluoride treatment. ▪ Services which are primarily cosmetic. (For residents of Texas: Services which are primarily cosmetic unless required for the treatment or correction of a congenital defect of a newborn child). ▪ Services or appliances which restore or alter occlusion or vertical dimension. ▪ Restoration of tooth structure damaged by attrition, abrasion or erosion unless caused by disease. ▪ Restorations or appliances used for the purpose of periodontal splinting. ▪ Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco. ▪ Personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss. ▪ Initial installation of a Denture to replace one or more teeth which were missing before such person was insured for Dental Insurance, except for congenitally missing natural teeth. ▪ Decoration or inscription of any tooth, device, appliance, crown or other dental work. ▪ Missed appointments. ▪ Services covered under any workers' compensation or occupational disease law. ▪ Services covered under any employer liability law. ▪ Services for which the employer of the person receiving such services is not required to pay. ▪ Services received at a facility maintained by the Policyholder, labor union, mutual benefit association, or VA hospital. ▪ Services covered under other coverage provided by the Policyholder. ▪ Temporary or provisional restorations. ▪ Temporary or provisional appliances. ▪ Prescription drugs. ▪ Services for which the submitted documentation indicates a poor prognosis. ▪ Services, to the extent such services, or benefits for such services, are available under a government plan. This exclusion will apply whether or not the person receiving the services is enrolled for the government plan. We will not exclude payment of benefits for such services if the government plan requires that Dental Insurance under the group policy be paid first. ▪ The following when charged by the dentist on a separate basis - Claim form completion; infection control such as gloves, masks, and sterilization of supplies; or local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide. ▪ Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing and biting of food. ▪ Caries susceptibility tests. ▪ Precision attachments associated with fixed and removable prostheses. ▪ Adjustment of a denture made within 6 months after installation by the same dentist who installed it. ▪ Duplicate prosthetic devices or appliances. ▪ Replacement of a lost or stolen appliance, cast restoration or denture. ▪ Intra and extraoral photographic images. ▪ Fixed and removable appliances for correction of harmful habits. ▪ Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards. ▪ Treatment of temporomandibular joint disorder. This exclusion does not apply to residents of Minnesota. ▪ Consultations.

Highlights
Financial Arrangement: Non-retrospectively Experience Rated
Situs is WISCONSIN
Only those residing in the United States are eligible for benefits
Dependent Child Definition: A Child is covered up to the end of the year in which a child turns age 26, regardless of student status.
Ortho coverage applies to: Adult (employee / spouse) & Child. Children are covered to the dependent age limit.
Late Entrant ***Employees who do not elect coverage during their 31-day initial application period must wait until a qualifying event or the next annual enrollment period to elect coverage.***

Alternate Benefits: Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement, and the associated procedure charge, on the least costly treatment alternative. If you and your dentist have agreed on a treatment which is more costly than the treatment upon which the plan benefit is based, your actual out-of-pocket expense will be: the procedure charge for the treatment upon which the plan benefit is based, plus the full difference in cost between the Negotiated Fee or, for out-of-network care, the actual charge, for the service rendered and the Negotiated Fee or R&C fee (if out-of-network care) for the service upon which the plan benefit is based. To avoid any misunderstandings, we suggest you discuss treatment options with your dentist before services are rendered, and obtain a pretreatment estimate of benefits prior to receiving certain high cost services such as crowns, bridges or dentures. You and your dentist will each receive an Explanation of Benefits (EOB) outlining the services provided, your plans reimbursement for those services, and your out-of-pocket expense. Procedure charge schedules are subject to change each plan year. You can obtain an updated procedure charge schedule for your area via fax by calling 1-800-942-0854 and using the MetLife Dental Automated Information Service.

Cancellation/Termination of Benefits: Coverage is provided under a group insurance policy (Policy form GPNP99 / G.2130-S) issued by MetLife. Coverage terminates when your membership ceases, when your dental contributions cease or upon termination of the group policy by the Policyholder or MetLife. The group policy terminates for non-payment of premium and may terminate if participation requirements are not met or if the Policyholder fails to perform any obligations under the policy. The following services that are in progress while coverage is in effect will be paid after the coverage ends, if the applicable installment or the treatment is finished within 31 days after individual termination of coverage: Completion of a prosthetic device, crown or root canal therapy.

Like most group benefit programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, reductions, limitations, waiting periods and terms for keeping them in force. Please contact MetLife or your plan administrator for costs and complete details.

Common Questions… Important Answers

Who is a participating dentist? A participating dentist is a general dentist or specialist who has agreed to accept negotiated fees as payment in full for services provided to plan members. Negotiated fees typically range from 15-45% below the average fees charged in a dentist's community for the same or substantially similar services.*

** Based on internal analysis by MetLife. Savings from enrolling in a dental benefits plan will depend on various factors, including how often members visit participating dentists and the cost for services rendered. Negotiated fees are subject to change. Negotiated fees for non-covered services may not apply in all states.*

How do I find a participating dentist? There are thousands of general dentists and specialists to choose from nationwide — so you are sure to find one who meets your needs. You can receive a list of these participating dentists online at www.metlife.com/mybenefits or call 1-800-942-0854 to have a list faxed or mailed to you.

What services are covered by my plan? All services defined under your group dental benefits plan are covered. Please review the enclosed plan benefits to learn more.

Does the Preferred Dentist Program offer any discounts on non-covered services? Negotiated fees may extend to services not covered under your plan and services received after your plan maximum has been met, where permitted by applicable state law. If permitted, you may only be responsible for the negotiated fee.

** Negotiated fees are subject to change. Negotiated fees for non-covered services may not apply in all states.*

May I choose a non-participating dentist? Yes. You are always free to select the dentist of your choice. However, if you choose a non-participating dentist, your out-of-pocket costs may be higher. He or she hasn't agreed to accept negotiated fees. So you may be responsible for any difference in cost between the dentist's fee and your plan's benefit payment.

Can my dentist apply for participation in the network? Yes. If your current dentist does not participate in the network and you would like to encourage him or her to apply, ask your dentist to visit www.metdental.com, or call 1-866-PDP-NTWK for an application.* The website and phone number are for use by dental professionals only.

** Due to contractual requirements, MetLife is prevented from soliciting certain providers.*

How are claims processed? Dentists may submit your claims for you which means you have little or no paperwork. You can track your claims online and even receive e-mail alerts when a claim has been processed. If you need a claim form, visit www.metlife.com/mybenefits or request one by calling 1-800-942-0854.

Can I find out what my out-of-pocket expenses will be before receiving a service? Yes. You can ask for a pretreatment estimate. Your general dentist or specialist usually sends MetLife a plan for your care and requests an estimate of benefits. The estimate helps you prepare for the cost of dental services. We recommend that you request a pre-treatment estimate for services in excess of $300. Simply have your dentist submit a request online at www.metdental.com or call 1-877-MET-DDS9. You and your dentist will receive a benefit estimate for most procedures while you are still in the office. Actual payments may vary depending upon plan maximums, deductibles, frequency limits and other conditions at time of payment.

How can I learn about what dentists in my area charge for different procedures? If you have MyBenefits you can access the Dental Procedure Fee Tool. You can use the tool to look up average in- and out-of-network fees for dental services in your area.* You'll find fees for services such as exams, cleanings, fillings, crowns, and more. Just log in at www.metlife.com/mybenefits.

** The Dental Procedure Fee Tool application is provided by go2dental.com. Inc., an independent vendor. Network fee information is supplied to go2dental.com by MetLife and is not available for providers who participate with MetLife through a vendor. Out-of-network fee information is provided by go2dental.com. This tool does not provide the payment information used by MetLife when processing your claims. Prior to receiving services, pretreatment estimates through your dentist will provide the most accurate fee and payment information.*

Can MetLife help me find a dentist outside of the U.S. if I am traveling? Yes. Through international dental travel assistance services* you can obtain a referral to a local dentist by calling +1-312-356-5970 (collect) when outside the U.S. to receive immediate care until you can see your dentist. Coverage will be considered under your out-of-network benefits.** Please remember to hold on to all receipts to submit a dental claim.

***International Dental Travel Assistance services are administered by AXA Assistance USA, Inc. AXA Assistance is not affiliated with MetLife and any of its affiliates, and the services they provide are separate and apart from the benefits provided by MetLife.*
*** Refer to your dental benefits plan summary for your out-of-network dental coverage.*

How does MetLife coordinate benefits with other insurance plans? Coordination of benefits provision in dental benefits plans are a set of rules that are followed when a patient is covered by more than one dental benefits plan. These rules determine the order in which the plans will pay benefits. If the MetLife dental benefit plan is primary, MetLife will pay the full amount of benefits that would normally be available under the plan. If the MetLife dental benefit plan is secondary, most coordination of benefits provisions require MetLife to determine benefits after benefits have been determined under the primary plan. The amount of benefits payable by MetLife may be reduced due to the benefits paid under the primary plan.

MPORTANT NOTICE

To obtain information or make a complaint:

You may call MetLife's toll free telephone number for information or to make a complaint at:

1-800-638-6420

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights, or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 490-1007

Web: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim, you should contact MetLife first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR CERTIFICATE: This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener información o para presentar una queja:

Usted puede llamar al número de teléfono gratuito de MetLife's para obtener información o para presentar una queja al:

1-800-638-6420

Usted puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos, o quejas al:

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas a:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 490-1007

Sitio web: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONES: Si tiene una disputa relacionada con su prima de seguro o con una reclamación, usted debe comunicarse con MetLife primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Texas.

ADJUNTE ESTE AVISO A SU CERTIFICADO: Este aviso es solamente para propósitos informativos y no se convierte en parte o en condición del documento adjunto.